

TEXAS HEALTH AND HUMAN SERVICES COMMISSION
INSPECTOR GENERAL

**SUMMARY OF RESULTS FROM
AUDITS OF ACUTE CARE
UTILIZATION MANAGEMENT IN
MANAGED CARE ORGANIZATIONS**

Informational Report



August 15, 2017
OIG Report No. AUD-17-016



HHSC IG

TEXAS HEALTH AND HUMAN
SERVICES COMMISSION
INSPECTOR GENERAL

WHY THE IG CONDUCTED THIS SERIES OF AUDITS

At approximately \$30 billion a year, the Medicaid program and Children's Health Insurance Program (CHIP) constitute over 29 percent of the total Texas budget. Approximately 88 percent of individuals enrolled in Medicaid or CHIP are members of a managed care organization (MCO).

MCOs are required to perform utilization management to ensure that members receive appropriate health care services, and that state and federal funds spent on managed care are used appropriately.

Utilization management includes review of (a) provider requests for members' current and future medical needs and (b) previously provided services for medical necessity, appropriateness, timeliness, effectiveness, and compliance with state and federal requirements.

The IG Audit Division conducted four audits of acute care utilization management in MCOs to evaluate the effectiveness of MCO acute care utilization management practices in ensuring that health care services provided are (a) medically necessary, (b) efficient, and (c) comply with state and federal requirements.

THIS INFORMATIONAL REPORT

This informational report, which is not an audit report under generally accepted government auditing standards, consists of audited and non-audited information compiled by the IG Audit Division. Some of the information reported has not been validated, but in combination with audited information is sufficient to satisfy the purpose of this report.

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WHAT THE IG REPORTED IN MCO UTILIZATION MANAGEMENT AUDITS

The results of IG Audit Division reports included in a series of four acute care utilization management audits can be summarized in four primary observations:

- MCOs face challenges in complying with different prior authorization processing requirements included in the Uniform Managed Care Contract (UMCC) and Texas Insurance Code (TIC).
- MCOs perform various analyses of utilization management data.
- MCOs assess and monitor personnel performance, but do not always ensure Texas-specific training is completed.
- The Medicaid and CHIP Services Department (MCSD) and audited MCOs are taking actions to address the findings identified in the audit reports.

Inconsistent Prior Authorization Processing Requirements

Each MCO is required by UMCC and TIC to notify requestors of prior authorization determinations within specific timeframes. There are two TIC sections that apply to MCOs – one for utilization review agents and another for health maintenance organizations. Neither rule aligns with the other or with the UMCC.

MCSD expressed its intention to discuss the discrepancy between notification timeframe requirements with TDI and update contractual time frames for prior authorization requests if appropriate.

MCOs Perform Various Analyses of Utilization Management Data

MCOs were analyzing utilization management data to help ensure appropriate utilization of resources. This included tracking utilization of services, monitoring providers to promote appropriate practice standards, and interacting with other programs, such as case management, disease management, compliance, quality improvement, credentialing, and fraud and abuse programs.

Texas-Specific Training Requirements Are Not Always Met

The IG Audit Division reviewed the four audited MCOs' training records related to acquired brain injury treatment and found they were aware of the TAC requirement. Noncompliance with the requirement arose when an MCO employed non-Texas personnel, as the Texas-specific training was not included in the employees' training curriculum.

Actions to Address Audit Issues

The IG Audit Division also noted issues specific to the MCOs' prior authorization processes, including unreliable electronic data for measuring timeliness, lack of supporting documentation, appeals processes that did not comply with all requirements, and some requests incorrectly denied for not being a covered benefit. To address these issues, the MCOs submitted corrective action plans to MCSD, and will update MCSD monthly detailing the status of each action plan.

HHSC Inspector General

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INTRODUCTION

This informational report, which is not an audit report under generally accepted government auditing standards, summarizes acute care¹ utilization management practices in managed care organizations (MCOs)² based on the results of four audits performed by the Texas Health and Human Services Commission (HHSC) Inspector General (IG) Audit Division.

The IG Audit Division conducted the four audits of acute care utilization management in MCOs in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States. The objective of the audits was to evaluate the effectiveness of MCO acute care utilization management practices in ensuring that health care services provided were (a) medically necessary, (b) efficient, and (c) in compliance with state and federal requirements. The audit scope covered state fiscal years 2014 and 2015, from September 1, 2013, through August 31, 2015. Unless otherwise described, any year referenced is the state fiscal year, which covers the period from September 1 through August 31.

This informational report is the last in a series of reports on acute care utilization management practices in MCOs. The first report was an informational report that provided background, context, and a compilation of information provided by 19 Texas Medicaid and Children's Health Insurance Program (CHIP) MCOs.³ The four subsequent audit reports detailed the IG Audit Division's conclusions regarding the compliance and effectiveness of the utilization management function for the four audited MCOs.

Background

Contracted MCOs are responsible for administering, on behalf of the State of Texas, billions of dollars of Medicaid and CHIP health care services each year through their health plans. The Uniform Managed Care Contract (UMCC) requires MCOs to perform utilization management functions, which are sometimes called utilization reviews. Utilization management is the process of integrating review and case management of services in a cooperative effort with other parties,

¹ "Acute care" is defined as preventive care, primary care, and other medical or behavioral health care delivered by a provider, or under the direction of a provider, for a condition having a relatively short duration. 1 Tex. Admin. Code § 353.2(2) (July 8, 2012) and (Sept. 1, 2014).

² An MCO is an organization that delivers and manages health care services under a risk-based arrangement. The MCO receives a monthly premium or capitation payment for each managed care member enrolled, based on a projection of what health care for the typical individual would cost.

³ Acute Care Utilization Management in Managed Care Organizations, IG Report No. IG-16-060 (Aug. 16, 2016).

including patients, employers, and providers. It includes evaluating (a) provider requests for members' current and future medical needs and (b) previously provided services for medical necessity,⁴ appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan. MCOs may perform the utilization management functions in-house, or contract with an outside entity to perform all or part of the activities associated with utilization management.⁵ A utilization review agent license is required for performance of medical reviews,⁶ and license holders must comply with applicable Texas Insurance Code (TIC) requirements.⁷ In addition to UMCC and TIC requirements, MCOs are also required to follow the Uniform Managed Care Manual (UMCM), which contains policies and procedures required of all MCOs participating in Medicaid and CHIP. The UMCM, as amended or modified, is incorporated by reference into the UMCC.

The IG Audit Division assessed utilization management functions at the following four MCOs, and published reports as part of this series of acute care utilization management audits:

- Superior HealthPlan, Inc. (Superior), issued November 30, 2016
- FirstCare Health Plans (FirstCare), issued February 21, 2017
- Community Health Choice, Inc. (Community), issued February 28, 2017
- Amerigroup Texas, Inc. (Amerigroup), issued May 30, 2017

These audits focused on acute care services, as opposed to long-term services and supports,⁸ and were limited to the Medicaid State of Texas Access Reform (STAR) and STAR+PLUS managed care programs. The IG Audit Division evaluated each MCO's utilization management function for the period from September 1, 2013, through August 31, 2015.

⁴ "Medical necessity" is a determination that health care services are reasonable and necessary to (a) prevent illness or medical conditions, and (b) treat conditions that cause suffering, pain, or physical deformity; limit function; or endanger life. 1 Tex. Admin. Code § 353.2(60) (July 8, 2012) and (Sept. 1, 2014).

⁵ A utilization review agent license is required for performance of medical reviews. The license is issued by the Texas Department of Insurance. 28 Tex. Admin. Code § 19.1704 (Feb. 20, 2013).

⁶ 28 Tex. Admin. Code § 19.1704 (Feb. 20, 2013).

⁷ 14 Tex. Ins. Code § 4201.057 (Apr. 1, 2007).

⁸ "Long-term services and supports" provide assistance for persons who are age 65 and older and those with chronic disabilities, with a goal of helping such individuals be as independent as possible. Long-term services and supports may be provided in institutional long-term care settings, such as nursing facilities, or in home or community-based settings.

The evaluation included, but was not limited to:

- Assessing utilization management practices applied to prior authorizations, denials, and appeals.
- Reviewing policies, procedures, and the utilization management program description to ensure compliance with state, federal, and contract requirements.
- Evaluating whether personnel making medical necessity determinations were qualified and currently licensed.
- Gaining an understanding of activities related to utilization monitoring, analysis, and reporting.

Texas Health and Human Services (HHS) agencies administer public health programs for the State of Texas. Within HHS, the HHSC Medicaid and CHIP Services Department (MCSD) oversees Medicaid and CHIP, which are jointly funded state-federal programs that provide medical coverage to low-income individuals. In 2014 and 2015, HHSC contracted with 19 MCOs to coordinate the delivery of Medicaid and CHIP services across the state of Texas. In 2015, there were approximately 4.4 million Texans enrolled in Medicaid or CHIP.⁹

The Medicaid program provides health care services, including medical, dental, prescription drug, disability, behavioral health, and long-term support services, to eligible individuals. Texas Medicaid provides services to some individuals through a traditional fee-for-service model,¹⁰ but most are enrolled through a managed care model.¹¹ Under managed care, the MCO receives a capitation payment¹² for each member enrolled, based on a projection of what health care for the typical individual would cost. If members' health care costs more, the MCO may suffer losses. If members' health care costs less, the MCO may profit. This gives the MCO an incentive to control costs. MCOs deliver Medicaid and CHIP services

⁹ Texas Medicaid and CHIP in Perspective, 11th ed., Texas Health and Human Services Commission (Feb. 2017).

¹⁰ Medicaid fee-for-service was the original service delivery model for Texas Medicaid introduced in 1967. In this model, enrolled Medicaid providers are reimbursed retrospectively for a Medicaid eligible health care service or services provided to a Medicaid eligible patient.

¹¹ Medicaid managed care was first introduced in pilot programs in Texas in 1993. In this model, the state contracts with MCOs who contract with Medicaid providers for the delivery of health care services to Medicaid enrollees. MCOs must provide the same services under managed care as provided under the traditional fee-for-service model.

¹² "Capitation payments" are monthly prospective payments HHSC makes to MCOs for the provision of covered services. HHSC makes capitation payments to MCOs at fixed, per member, per month, rates based on members' associated risk groups. These capitation payments include federal and state funds, and both medical and pharmacy payments.

through their networks of providers. In federal fiscal year 2015, Texas spent \$30 billion on Medicaid and CHIP,¹³ which represented 29 percent of the entire 2015 state budget.

Medicaid serves primarily low-income families, children, related caretakers of dependent children, pregnant women, people age 65 and older, and adults and children with disabilities. Through the STAR program, Medicaid provides services for pregnant women, newborns, and children. Through the STAR+PLUS program, Medicaid provides health services for individuals age 65 or older, and individuals with a disability requiring long-term health care services. Through the STAR Health program, Medicaid provides services to children and young adults currently or previously participating in the Department of Family and Protective Services conservatorship or foster care programs. CHIP provides health coverage to low-income, uninsured children in families with incomes too high to qualify for Medicaid.

Table 1 shows a breakdown of the four audited MCOs’ average monthly member counts and gross premiums for the Medicaid STAR program in 2014 and 2015. Overall, from 2014 to 2015, there was a 10 percent (147,640) increase in the number of members served and a 2 percent (\$107.5 million) decrease in the gross premiums paid to the MCOs. Over the two years, the four MCOs received a total of \$9.4 billion. Gross premiums include gross capitation payments and delivery supplemental payments.¹⁴

Table 1: Medicaid STAR Member Counts and Gross Premiums for 2014 and 2015 by MCO

| MCO | Fiscal Year | # of Members (monthly average) ¹⁵ | Gross Premiums (\$ billions) |
|------------|-------------|--|------------------------------|
| Superior | 2014 | 691,142 | \$ 2.43 |
| | 2015 | 737,285 | 2.27 |
| Amerigroup | 2014 | 514,466 | 1.41 |
| | 2015 | 575,747 | 1.43 |
| Community | 2014 | 203,440 | 0.63 |
| | 2015 | 236,864 | 0.68 |
| FirstCare | 2014 | 88,252 | 0.29 |
| | 2015 | 95,044 | 0.27 |

Source: HHSC 2014 Year-End 334-Day Financial Statistical Report (FSR) and HHSC 2015 Year-End 90-Day FSR

¹³ This amount excludes Medicaid funding for Disproportionate Share Hospital, Upper Payment Limit, Uncompensated Care, and Delivery System Reform Incentive Payment funds. Medicaid and CHIP amounts are for the federal fiscal year, and the state budget reflects the state fiscal year, which begins one month prior to the federal fiscal year.

¹⁴ A “delivery supplemental payment” is a one-time payment per pregnancy to STAR, CHIP, and CHIP Perinatal MCOs for the delivery of live or still births.

¹⁵ This is the monthly average number of program enrollees.

Two of the audited MCOs also participated in the STAR+PLUS program. Table 2 shows a breakdown of these two MCOs' average monthly member counts and gross premiums for the Medicaid STAR+PLUS program in 2014 and 2015. Over the two-year period, there was an increase in the number of members served and the gross premiums paid to the MCOs. There was a 24 percent (56,218) increase in the number of members and a 43 percent (\$1.11 billion) increase in the gross premiums paid to the MCOs. Over the two years, the two MCOs received a total of \$6.3 billion.

Table 2: Medicaid STAR+PLUS Member Counts and Gross Premiums for 2014 and 2015 by MCO

| MCO | Fiscal Year | # of Members (monthly average) | Gross Premiums (\$ billions) |
|------------|-------------|--------------------------------|------------------------------|
| Superior | 2014 | 111,711 | \$ 1.38 |
| | 2015 | 146,371 | 1.97 |
| Amerigroup | 2014 | 118,923 | 1.22 |
| | 2015 | 140,481 | 1.74 |

Source: HHSC 2014 Year-End 334-Day FSR and HHSC 2015 Year-End 90-Day FSR

OBSERVATIONS

Observations based on the IG Audit Division's acute care utilization management audits are organized within the following categories:

- Prior Authorization Timeliness Requirements
- Prior Authorization Processes
- Utilization Management Data
- Utilization Management Personnel
- HHSC Oversight of MCO Utilization Management

Details about each of these categories are included in the information that follows.

PRIOR AUTHORIZATION TIMELINESS REQUIREMENTS

Two different timeliness requirements for MCOs to notify requestors of prior authorization determinations currently exist. One requirement is contained in the UMCC and the other is contained in TIC, which is the code for the Texas Department of Insurance (TDI). These differences, especially when combined with timelines included in MCO internal processes that may not align with either or both of the state requirements, create compliance challenges for MCOs.

Observation 1: UMCC and TIC Timeliness Requirements for MCO Notification of Prior Authorization Determinations are Different

MCOs must comply with UMCC requirements but, as licensed review agents, must also comply with applicable TIC requirements. However, not all requirements in the UMCC and TIC align. For example, timeliness requirements that apply to MCO prior authorization processes are different for notification of prior authorization request determinations.

Notification of Prior Authorization Request Determinations

The Code of Federal Regulations (CFR) requires each MCO to provide notice of prior authorization determinations as expeditiously as the enrollee's health condition requires, and within state-established timeframes that may not exceed 14 calendar days following the receipt of the request for service. In Texas, those state-established timeframes are set forth in the UMCC and TIC.

The difference occurs because in TIC there are two sections that apply to MCOs—one for utilization review agents (URA) and another for health maintenance organizations (HMO). Neither requirement aligns with the other or with the

UMCC. The UMCC and TIC's URA requirement both have timelines based on business days, while the TIC HMO requirement is based on calendar days. TIC's URA requirement has different timelines based on whether the determination is favorable or unfavorable, while the UMCC and TIC's HMO requirement make no such distinction. Furthermore, TIC's URA requirement requires all information necessary to complete the review be received before triggering the timeline, but TIC's HMO requirement does not. Details of the different requirements follow.

UMCC

Under the UMCC, the MCO must issue all coverage (prior authorization) determinations,¹⁶ including favorable and adverse determination notices, according to the following timeline:

- Within three business days after receipt of the request for authorization of services.¹⁷

TIC – URA

Under TIC, the MCO must issue coverage determinations according to timelines dictated by whether the determination is favorable or adverse, as follows:

- Notice of a favorable determination¹⁸ must be transmitted no later than the second working day after the date that a utilization review agent receives a request for utilization review with all information necessary to complete the review.¹⁹
- Notice of an adverse determination must be provided within three working days to the provider of record and the patient.²⁰

¹⁶ The timeline for certain request determinations may be extended if an MCO receives a request for a member under age 21, and the request does not contain complete documentation or information. In such cases, the MCO will contact the provider describing the information necessary to complete the prior authorization process and will allow the provider seven calendar days to provide additional information. HHSC Uniform Managed Care Manual, Chapter 3.22, Notification Process for Incomplete Prior Authorization Requests, v. 1.0 (Jan. 15, 2010) through v. 2.0 (Nov. 15, 2014).

¹⁷ Uniform Managed Care Contract, Attachment B-1 § 8.1.8, v. 2.6 (Sept. 1, 2013) through v. 2.15 (June 1, 2015).

¹⁸ The written notification of a favorable determination made in utilization review must be mailed or electronically transmitted as required by Insurance Code 4201.302. 28 Tex. Admin. Code § 19.1709 (Feb. 20, 2013).

¹⁹ 14 Tex. Ins. Code § 4201.302 (Apr. 1, 2007).

²⁰ 14 Tex. Ins. Code § 4201.304 (Apr. 1, 2007).

TIC – HMO

Under the TIC HMO requirement, the HMO, on receipt of a request from a participating physician or provider for preauthorization, shall review and issue a determination indicating whether the health care services are preauthorized according to the following timeline:

- The determination must be issued and transmitted not later than the third calendar day after the date the request is received by the HMO.²¹

Because of these differences, an MCO could be in compliance with UMCC requirements, while at the same time be out of compliance with TIC requirements.

The four audited MCOs each had internal notification timeliness policies for issuing coverage determinations that met or exceeded UMCC guidelines. Two of the audited MCOs had timeliness policies that were more restrictive than the UMCC requirements:

- One MCO's policy was consistent with TIC's URA guidelines.
- One MCO's policy was similar to UMCC guidelines, but was more restrictive because while it required notification within three business days of the receipt of the request, the MCO counted the day received as day one. While the UMCC does not define day one, statutory guidelines for calculating a period of days indicate that day one would be the day after the prior authorization request is received.²²

In summary, three of the audited MCOs did not have policies that complied with TIC requirements. Consistent with this, audit results indicated that MCO noncompliance with TIC timeless requirements was more common than noncompliance with UMCC requirements.

Notification of prior authorization request determinations did not consistently meet UMCC, TIC, and MCO timeliness requirements. Non-compliance rates with UMCC timeliness requirements ranged from 4 percent to 23 percent, while non-compliance rates with the more stringent TIC requirements ranged from 8 percent to 40 percent. Non-compliance with MCO internal timeliness requirements ranged from 5 percent to 33 percent.

²¹ 6 Tex. Ins. Code § 843.348 (Sept. 1, 2005).

²² In calculating a period of days, the first day is excluded and the last day is included. If the last day of any period is a Saturday, Sunday, or legal holiday, the period is extended to include the next day that is not a Saturday, Sunday, or legal holiday. 3 Tex. Gov. Code § 311.014 (Sept. 1, 1985).

One audited MCO did not realize that TIC requirements applied to Medicaid, and another indicated that following TIC requirements could lead to higher costs to implement the more rigorous timeline for processing prior authorization determination notices.

One audited MCO indicated that even the existing UMCC three-day requirement for issuing prior authorization determinations could lead to unnecessary denials and appeals. MCOs may deny otherwise appropriate services because they do not have enough time to receive and adequately vet additional clinical information without missing the notification deadline. This MCO indicated that having more time to make prior authorization determinations may enable the MCO to obtain all clinical information, thus reducing the number of denials and appeals, and improving member care.

MCSD expressed its intention to discuss the discrepancy between notification timeliness requirements with TDI, with the goal of establishing consistent timeliness requirements for notice of prior authorization determinations. If an agreement with TDI is reached and any UMCC changes are required, MCSD will work with the HHSC Office of Chief Counsel to amend applicable UMCC provisions.

PRIOR AUTHORIZATION PROCESSES

An MCO's utilization management function requires policies, procedures, and organizational structures to comply with federal and state regulations for prior authorization. HHSC does not mandate a specific approach for MCOs to develop utilization management policies or organizational structures. Instead, HHSC gives MCOs latitude to determine how they will each comply with federal and state requirements.

Prior authorization, or preauthorization, requires the provider to formally request a medical necessity determination, and receive approval from the MCO, prior to rendering certain services to MCO members. Each MCO determines the services for which it requires the provider to submit a prior authorization request.

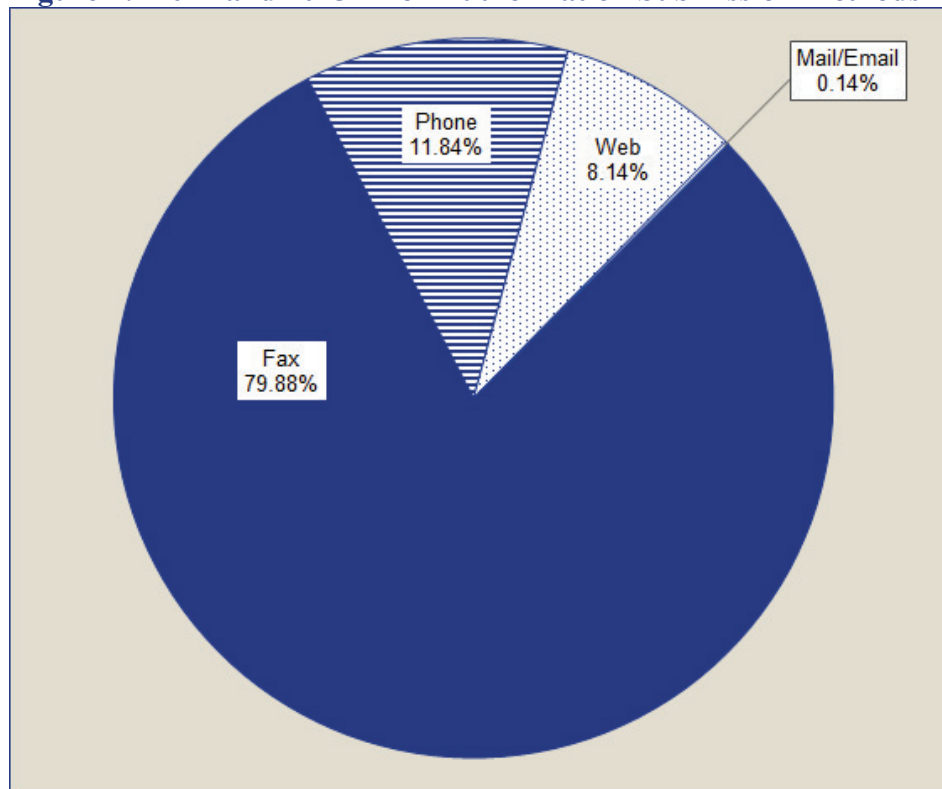
The IG Audit Division's evaluation of the MCOs' prior authorization policies and practices highlighted variances among the MCOs. Details regarding these variances are presented in the observations that follow.

Observation 2: MCOs Offer a Variety of Ways for Providers to Submit Prior Authorization Requests

Providers used several methods, including fax, phone, web portals, mail, and email to submit prior authorizations to MCOs.

Figure 1 shows the combined breakdown of 2014 and 2015 prior authorization request submission methods for two²³ MCOs. Approximately 80 percent (733,406 of 918,166) of the combined prior authorization requests submitted by providers to the two MCOs were received via fax.

Figure 1: 2014 and 2015 Prior Authorization Submission Methods



Source: Self-reported MCO Data

Faxed prior authorization requests, along with phone, mailed, and emailed requests, required MCOs to manually enter the details of the request into their utilization management systems to be processed. However, all four MCOs provided a web portal for prior authorization submission. The UMCC requires MCOs to provide a provider portal to reduce administrative burden on network providers at no cost to

²³ Two of the four MCOs audited did not provide the prior authorization request submission method within their prior authorization populations.

the providers. An effective provider portal brings information together from diverse sources in a uniform way. According to the UMCC,²⁴ the provider portal functionality must include:

- Client eligibility verification
- Submission of electronic claims
- Prior authorization requests
- Claims appeals and reconsiderations
- Exchange of clinical data and other documentation necessary for prior authorization and claim processing

The MCOs encouraged providers and practitioners to use the web portals, which provide real-time access to the status of a prior authorization and can limit the manual entry of prior authorization information by the MCO.

Benefits to a provider for using an MCO web portal include the ability to:

- Verify member eligibility and benefits
- Submit a prior authorization request and subsequent claim for payment
- Check the status of a prior authorization request and subsequent claim
- Submit an appeal
- Submit a corrected claim

Due to the short processing time and the need to manually receive and enter most prior authorization information into their utilization management systems, MCOs face challenges processing prior authorizations timely and accurately. Having more providers submit electronic prior authorization requests through the MCOs' web portals can improve the prior authorization process by reducing the number of MCO data entry errors and increasing the efficiency of the prior authorization request intake process.

Additionally, as of September 1, 2015, TDI's Texas Standard Prior Authorization Request Form for Health Care Services must be accepted by an MCO if the plan requires prior authorization of health care services. The intended use stated on the form explains: "Use this form to request authorization by fax or mail when an issuer requires prior authorization of a health care service. An Issuer may also provide an electronic version of this form on its website that you can complete and submit electronically, through the issuer's portal, to request prior authorization of a health care service." MCOs may still have their own unique prior authorization request forms, but having a form that is accepted by all MCOs helps standardize the information needed to process a prior authorization.

²⁴ Uniform Managed Care Contract, Attachment B-1 § 8.1.18.5 v. 2.15 (June 1, 2015).

The integration and implementation of electronic prior authorizations may expedite members' access to health care services. In addition, standardization of data within and across MCOs enables better analysis and monitoring of prior authorizations and utilization management. Currently, since the primary means to submit prior authorizations is through fax, it is important to have controls in place to ensure the accuracy of the data being entered in the MCOs' utilization management systems.

Observation 3: MCO Electronic Data Used to Track Prior Authorization Timeliness Was Not Always Reliable

The IG Audit Division identified issues with the reliability of prior authorization data at all four audited MCOs. None of the MCOs had data input or edit checks in place to help ensure prior authorization request received dates and notification dates were accurate. The audited prior authorization populations contained prior authorization received dates, prior authorization determination dates, or both prior authorization received and determination dates that occurred outside the audit scope period of September 1, 2013, through August 31, 2015. The out-of-scope prior authorization dates for the four audited MCOs ranged from years 1813 to 2201.

MCOs are required to maintain a management information system that enables the MCO to meet UMCC requirements, including all applicable state and federal laws, rules, and regulations. The management information system must have the capacity and capability to capture and utilize various data elements required for MCO administration.

Not having information technology controls, such as data input and edit checks, or other control mechanisms over the data entry of prior authorization information can hinder MCO and HHSC efforts to monitor timeliness and ensure compliance with the UMCC and TIC. MCSD has required the audited MCOs to (a) submit corrective action plans to implement control mechanisms that will improve the reliability of prior authorization request received dates and notification of prior authorization determination dates maintained in their management information systems and (b) update MCSD monthly on the status of each action plan.

Observation 4: MCOs Use Reporting Tools to Track Prior Authorization Requests

Utilization management personnel reviewed prior authorization requests to help ensure members received appropriate and timely health care services. MCOs are required to evaluate prior authorization requests and issue coverage determinations within timelines established in the UMCC, the UMCM, and TIC. The IG Audit Division observed that three of the four MCOs used a real-time reporting tool to track and monitor the timeliness of processing prior authorization requests.

Utilization management managers at these three MCOs monitored the workflow demands at the unit and individual level to identify potential issues in meeting required timelines. One MCO used a manual reporting process during the audit period to monitor the timeliness of processing prior authorization requests. This reporting process required utilization management managers to review each employee's work queue to determine the number of requests outstanding and to identify potential issues in meeting required timelines. During the audit, this MCO was actively transitioning to a real-time reporting tool to assist with its tracking and monitoring of prior authorization requests.

Observation 5: Differences in MCO Processes for Administrative Denials Can Result in Inconsistent Delivery of Services and Appeal Rights

By using different processes for administering non-medical necessity denials, MCOs may be administering administrative denials inconsistently, which may lead to some members experiencing delays or denials of services inappropriately. A prior authorization request may be denied for reasons other than lack of medical necessity as defined by the MCOs, which may use the term "administrative denial" to describe these denials.

The audited MCOs defined the following reasons for administrative denials:

- Member ineligibility
- Requested service specifically excluded from the benefit package (also referred to as not-a-covered benefit)
- Failure to obtain prior authorization before services were provided
- Request for out-of-network services that are available in-network
- Late or non-notification of admission
- Non-contracted provider

Descriptions of the administrative denial processes for each of the four audited MCOs follow:

- Intake personnel reviewed the prior authorization request and determined whether the request for services should result in an administrative denial. Members or their representatives had the right to file a complaint²⁵ or request a fair hearing,²⁶ but did not have appeal rights.²⁷
- A nurse reviewer reviewed the prior authorization request and determined whether the request should result in an administrative denial. Members or their representatives had the right to file a complaint, request a fair hearing, or request an appeal of the administrative denial. The appeal, if requested, would be reviewed by a physician regardless of the member's age.
- A nurse reviewer and physician reviewer reviewed the prior authorization request before administering an administrative denial. Members could request an appeal of an administrative denial for services considered "not a covered benefit." If an appeal for a "not a covered benefit" administrative denial was requested for a member under 21 years old, a physician would review it. If the member was 21 or older, the nurse reviewer could review the appeal and either approve or deny the appeal due to it not being a covered benefit.
- A nurse reviewer reviewed the prior authorization request and determined whether the request should result in an administrative denial. Members or their representative could file a complaint with HHSC, as well as request a fair hearing.

The IG Audit Division noted that the general reasons for an administrative denial were similar among the four audited MCOs; however, the processes and personnel responsible for administering the administrative denials varied. The UMCC does not define or provide guidance about how to process administrative denials.

²⁵ Per the UMCC, "complaint" (Medicaid only) means an expression of dissatisfaction expressed by a complainant, orally or in writing to the MCO, about any matter related to the MCO other than an action. An action means: (a) the denial or limited authorization of a requested Medicaid service, including the type or level of service, (b) the reduction, suspension, or termination of a previously authorized service, (c) the denial in whole or in part of payment for service, (d) the failure to provide services in a timely manner, (e) the failure of an MCO to act within the timeframes set forth in the Contract and 42 C.F.R. § 438.408(b), or (f) for a resident of a rural area with only one MCO, the denial of a Medicaid members' request to obtain services outside of the network. An adverse determination is one type of action.

²⁶ Per the UMMC, "fair hearing" means the process adopted and implemented by HHSC in 1 Tex. Admin. Code Chapter 357, in compliance with federal regulations and state rules relating to Medicaid fair hearings.

²⁷ "Appeal" (Medicaid only) means the formal process by which a member or his or her representative request a review of the MCO's action.

One audited MCO, however, did not follow its own process. It incorrectly denied 2 of 32 prior authorizations tested (6.3 percent) for not being a covered benefit when the prior authorization requests should have been reviewed for medical necessity. MCSD has required the audited MCO to implement a process to ensure eligible health care services are not incorrectly denied as not a covered benefit.

Observation 6: MCOs Use Similar Evidence-Based Criteria to Determine Medical Necessity

The UMCC does not specify which evidence-based criteria MCOs must use when making medical necessity determinations. However, the UMCC does require Medicaid MCOs to provide services and benefits described in the Texas Medicaid Provider Procedures Manual (TMPPM).²⁸ TMPPM is a manual published on behalf of HHSC that contains the policies and procedures required of all health care providers who participate in the Texas Medicaid program.²⁹ The manual is updated regularly, usually monthly.

Each of the four audited MCOs has corporate or health plan clinical policies it uses in determining medical necessity. For the majority of the MCOs, internal clinical policies are the initial criteria used in evaluating medical necessity, but one MCO lists the TMPPM and Centers for Medicare and Medicaid Services (CMS) guidelines as the initial criteria used. McKesson’s InterQual and MCG,³⁰ which are purchased industry clinical criteria, are the next most prevalent criteria used. Other nationally recognized criteria³¹ and the medical directors’ expertise are additional common criteria used by the MCOs.

Table 3: MCO Evidence-Based Criteria Priority Ranking for Assessing Medical Necessity

| Criteria | MCO 1 | MCO 2 | MCO 3 | MCO 4 |
|--|------------------|-------|-------|-------|
| | Priority Ranking | | | |
| Corporate and/or Health Plan Clinical Policies | 1 | 2 | 1 | 1 |
| Purchased Industry Clinical Criteria | 2 | 3 | 2 | 2 |
| TMPPM | 3 | 1 | 3 | 4 |
| Other Nationally Recognized Criteria | N/A | 4 | 4 | 3 |
| Medical Director Expertise | 4 | 5 | 5 | 5 |

Source: IG Audit Division

²⁸ Uniform Managed Care Contract, Attachment B-1 § 8.1.2, v. 2.6 (Sept. 1, 2013) through v. 2.15 (June 1, 2015).

²⁹ Uniform Managed Care Contract, Attachment A, Article 2: Definitions, v. 2.6 (Sept. 1, 2013) through v. 2.15 (June 1, 2015).

³⁰ MCG guidelines were formerly known as Milliman Care Guidelines.

³¹ Other nationally recognized criteria may include (a) Hayes Knowledge Center, (b) national specialty society-developed guidelines, and (c) evidence-based medical literature.

Observation 7: Requirements Related to Incomplete Prior Authorization Requests for Members Under 21 Years of Age Are Inconsistent

The UMCM requires MCOs to follow certain processing requirements when the MCO receives an incomplete request for prior authorization for a member under age 21.³² In such cases, the MCO must:

- Return the request to the Medicaid provider with a letter describing the documentation that needs to be submitted, and when possible, contact the Medicaid provider by telephone, and obtain the information necessary to complete the prior authorization process.
- If the documentation or information is not provided within 16 business hours of the MCO's request to the Medicaid provider, the MCO will send to the member (a) a letter explaining that the request cannot be acted upon until the documentation or information is provided and (b) a copy of the request to the Medicaid provider for the missing documentation.
- If the documentation or information is not provided to the MCO within seven calendar days of its letter to the member, the MCO will send a notice to the member informing the member of its denial of the requested service due to the incomplete documentation or information, and provide the member an opportunity to request an appeal through the MCO's internal appeals process and the HHSC fair hearing process.

MCOs must comply with the UMCM, but may face challenges in ensuring that they also comply with TIC.³³ TIC requires an MCO to provide a notice of adverse determination within three working days, while the UMCM allows the MCO additional days to obtain information necessary to complete the prior authorization process before sending a notice of an adverse determination. MCSO will coordinate with the HHSC Office of Chief Counsel to work with TDI to harmonize the UMCM and TIC requirements.

³² Uniform Managed Care Manual, Chapter 3.22 v. 1.0 (Jan. 15, 2010) through v. 2.0 (Nov. 15, 2014).

³³ 14 Tex. Ins. Code § 4201.304 (Apr. 1, 2007).

Observation 8: MCOs Generally Complied With Appeal Requirements

The UMCC requires MCOs to develop, implement, and maintain an appeal process that complies with state and federal laws and regulations.³⁴ An appeal is a formal process by which a member (or member's representative) requests review of an MCO action.

During the prior authorization review process, providers request approval of services. The MCO reviews the requested service for applicability as a covered service, then checks for medical necessity and makes a determination to approve, deny, or partially approve the requested service.

If the MCO makes an adverse determination for a prior authorization request, it sends an adverse determination letter (also called a denial letter) to both the member (or member's representative) and the provider, detailing the:

- Principal reasons and clinical basis for the adverse determination
- Description or source of clinical guidelines used in the adverse determination
- Professional specialty of the individual making the determination
- Procedures for filing a complaint or appeal
- Member's right to a fair hearing by an independent review organization

When an appeal is received from a member, a member's representative, or a provider, the MCO must send an appeal acknowledgement letter to the appealing party within five business days acknowledging receipt of the appeal request. The standard appeal process must be completed within 30 calendar days after receipt of the initial request.

An appeal resolution letter is sent to the member (or member's representative) and the provider, specifying the:

- Reason and clinical basis for the determination
- Criteria used for the determination
- Professional specialty of the physician making the determination
- Procedures for filing a complaint
- Appealing party's rights and process for an independent review

³⁴ Uniform Managed Care Contract, Attachment B-1, § 8.2.6.2 Medicaid Standard Member Appeal Process and § 8.2.6.3 Expedited Medicaid MCO Appeals, v. 2.6 (Sept. 1, 2013) through v. 2.15 (June 1, 2015).

Of the four MCOs audited, two could not demonstrate compliance with all appeal requirements:

- One MCO did not have a process in place to ensure all source documents were retained for all appeal requests and notifications, and consequently could not demonstrate whether timeliness requirements were met.
- One MCO's prior authorization adverse determination and appeal resolution letters did not always contain all required notification elements. Additionally, the MCO did not consistently process appeal acknowledgement letters and resolution letters timely.

MCSD has required the audited MCOs to submit corrective action plans ensuring their appeal processes comply with UMCC requirements regarding timeliness and documentation.

UTILIZATION MANAGEMENT DATA

The audited MCOs analyzed utilization management data to help ensure appropriate utilization of resources. Analysis included tracking utilization of services to guard against over-utilization and under-utilization, monitoring providers to promote appropriate practice standards, and interacting with other MCO functional activities, such as case management, disease management, compliance, quality improvement, credentialing, and fraud and abuse. Details regarding some of the analysis performed by MCOs are included in the observations that follow.

Observation 9: MCOs Assess the Effectiveness and Efficiency of Their Utilization Management Programs

The UMCC requires MCOs to routinely assess the effectiveness and efficiency of their utilization management programs. The four audited MCOs each conducted annual assessments of the effectiveness and efficiency of their respective utilization management programs. This assessment served as a reporting mechanism to detail the MCO's (a) progress and outcomes related to its initiatives, (b) established goals, (c) accomplishments, (d) barriers encountered, and (e) subsequent year's objectives.

Observation 10: MCOs Analyze Data to Identify Members Who Could Benefit From Case Management or Disease Management

The audited MCOs each analyzed and monitored member utilization, as required by the UMCC. Approaches the MCOs used in their analysis included identifying:

- Member utilization trends occurring within the health plan's population or a subsection of its population
- Member utilization rates occurring outside the normal ranges
- Future utilization trends by performing various predictive analytics³⁵

MCOs performed predictive analytics to proactively identify members who might benefit from participating in a case management or disease management program. These members may be at risk of developing, or have developed, certain conditions such as asthma, diabetes, or other chronic medical conditions. The purpose of the programs was to assist members in receiving coordinated care to help manage their complex or chronic health condition. Potential benefits of performing this analysis include:

- Reducing medical costs
- Improving clinical outcomes
- Increasing member and provider satisfaction
- Improving compliance with specific state requirements and expectations

Post-service analysis of utilization management data allows MCOs to identify cases in which a member's utilization differs from that of comparable individuals. Predictive analytics may help MCOs identify members who could benefit from case management, potentially lowering medical costs and improving quality of care delivered to members in the future.

³⁵ Predictive analytics is the branch of advanced analytics which is used to make predictions about unknown future events. Predictive analytics uses many techniques from data mining, statistics, modeling, machine learning, and artificial intelligence to analyze current data to make predictions about the future. <http://www.predictiveanalyticstoday.com/what-is-predictive-analytics/>

Observation 11: MCOs Compare Utilization Patterns Against Clinical and Quality Benchmarks Data

The UMCC requires MCOs to compare utilization patterns of providers. The four audited MCOs analyzed and monitored provider utilization through a process that measured provider performance against national and state-specific clinical and quality benchmarks. Three of the four audited MCOs compiled the specific performance measures into a formal document, which was shared with each provider as a provider profile.

The MCOs used the profiles to:

- Provide information to providers regarding their clinical and quality performance relative to peers
- Identify providers employing best practices
- Identify opportunities for provider improvement

To help promote appropriate practice standards, MCOs might intervene if providers' performance fell outside the normal range of their peers.

Interventions might include, but were not limited to:

- Educating providers
- Sharing best practices and documentation tools
- Assisting with analyzing barriers to care
- Developing action plans
- Performing ongoing reviews of medical records
- Initiating peer reviews (may be part of the credentialing process)
- Removing providers from the health plan network

Sharing utilization management data among their network providers helped MCOs improve provider compliance with clinical practice guidelines and performance targets and may be part of an MCO's provider incentive and improvement programs. Provider improvement programs also varied among MCOs and focused on areas the MCO wanted to improve. For example, an MCO might collaborate with providers to determine why a particular phenomenon was occurring or create a workgroup to reduce potentially preventable events such as emergency department visits and readmissions.

UTILIZATION MANAGEMENT PERSONNEL

Utilization management blends the need for providing members with health care that is provided at an appropriate level of care, place of service, and quality, while actively managing costs. Utilization management personnel are at the forefront of this challenge as they are responsible for reviewing a member's eligibility and requested medical services. Details regarding some of the activities MCOs perform to capitalize on their utilization management efforts are included in the observations that follow.

Observation 12: Most MCO Personnel Receive Required Training

The IG Audit Division sent a survey to 19 MCOs in January 2016 to gather information on the types of training and continuing education the MCOs provide to utilization management personnel. MCO responses indicated that education included courses for new hires, refresher training, and other required annual training. The courses and number of training hours varied among the MCOs. For example, 2 of the 4 audited MCOs provided structured new-hire training of 80 to 90 hours, while another MCO included online orientation training consisting primarily of the employee reading policies and guides, then participating in on-the-job training.

Each MCO determined its training requirements to comply with Texas Administrative Code (TAC) and TIC.³⁶ TAC requires personnel performing utilization review to (a) be appropriately trained, qualified, and currently licensed or otherwise authorized to provide health care services from a licensing agency in the United States and (b) receive training related to acquired brain injury treatment.³⁷

TIC requires MCOs to provide adequate training to personnel responsible for precertification, certification, and recertification of services or treatment relating to acquired brain injury to prevent denial of coverage in violation of TIC³⁸ and to avoid confusing medical benefits with mental health benefits.³⁹

The four audited MCOs were aware of TAC and TIC requirements to provide training related to acquired brain injury treatment, and provided the required

³⁶ 8 Tex. Ins. Code § 1352.004 (Sept. 1, 2007).

³⁷ 28 Tex. Admin. Code § 19.1706 (Feb. 20, 2013).

³⁸ A health benefit plan must include coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and treatment, neurofeedback therapy, and remediation required for and related to treatment of an acquired brain injury. 8 Tex. Ins. Code § 1352.003 (Sept. 1, 2013).

³⁹ 8 Tex. Ins. Code § 1352.004 (Sept. 1, 2007).

training to most employees. However, none of the four audited MCOs fully complied with the training requirement. A summary of each audited MCO's test results in this area follows:

- One did not provide evidence that two out-of-state contractors received the required training.
- One did not provide evidence that 26 personnel received the required training, which included 11 employee physicians, 3 contractor physicians, and 12 nurse reviewers that operate outside of Texas.
- One did not provide documentation for 20 personnel required to take the training.
- One did not provide evidence that seven personnel received the required training.

MCSD has required the audited MCOs to implement processes to ensure and adequately document that all personnel involved in prospective utilization review receive required Texas Medicaid trainings, including training in acquired brain injury.

Observation 13: MCOs Monitor the Consistency and Quality of Utilization Review Personnel Performance

MCOs monitored utilization management personnel performance and quality of work through audits of completed cases and inter-rater reliability (IRR) assessments. IRR is an assessment of staff conducting utilization reviews to ensure staff are making decisions and assessments consistent with their peers, clinical criteria, and guidelines. IRR is not a UMCC requirement, but is a best practice.

MCOs stated they performed audits of utilization management personnel's completed cases to ensure performance metrics and quality of case work expectations were met. Items reviewed during the audits included (a) appropriateness of the evidence-based criteria referenced, (b) accuracy and completeness of case notes, and (c) accuracy and completeness of the determination letter sent to the member and provider.

All four MCOs performed IRR assessments to help ensure the consistent application of evidence-based clinical criteria and medical necessity determinations. The IG Audit Division observed differences in the assessment composition and minimum passing requirements among the MCOs. The composition consisted of either an assessment provided by a third-party vendor with multiple questions on focused topics or cases chosen by the medical director

or utilization manager. For instance, one medical director stated the cases selected for the assessment focused on frequently received requests, such as those for speech therapy and pre-natal care, and other specific or general issues about which he wanted to educate utilization review staff.

The minimum IRR assessment passing requirement differed among the MCOs. Two of the four MCOs required a minimum passing score of 90 percent, and the third required a score of 80 percent. When the minimum passing score was not met, three of the four MCOs required the utilization reviewer to either receive remediation training, retake the test, or both.

The fourth MCO did not have a minimum passing score, but stated that its goal was for staff to achieve a score of 70 percent or greater. Rather than create a formal corrective action plan, the chief medical officer conducted post-assessment discussions with all reviewers to educate the reviewers on the correct determination and the rationale for the determination. If an individual's performance was not considered satisfactory, the reviewer's manager would spend additional time discussing the concept with the employee.

HHSC OVERSIGHT OF MCO UTILIZATION MANAGEMENT

Oversight and contract management functions are not facilitated exclusively by a single area, but are instead shared efforts among multiple MCSD business areas. This has resulted in a robust governance structure, providing comprehensive contract oversight, including the identification of anomalies in service utilization. One recent addition to the functions in MCSD with oversight responsibilities is discussed in the observation that follows.

Observation 14: HHSC Established the Acute Care Utilization Review Unit

HHSC established the Acute Care Utilization Review (ACUR) Unit in 2016 in response to a legislative mandate.⁴⁰ ACUR is tasked with monitoring MCOs to determine whether MCO prior authorization and utilization review processes appropriately deny authorization of unnecessary or inappropriate services. Additionally, ACUR will safeguard against access to care disparities by evaluating whether MCOs are under-utilizing acute care services by denying necessary and appropriate services.

MCSD is establishing processes for an integrated approach to routine, operational on-site reviews of HHSC's managed care contractors. MCSD will perform coordinated operational reviews and contract compliance of MCO and dental

⁴⁰ 4 Tex. Gov. Code § 531.076 (Sept. 1, 2013).

maintenance organization functions beginning September 2017. The ACUR unit will provide oversight of MCO prior authorization activities as one of the operational review modules.

CONCLUSION

HHSC and MCOs share accountability for ensuring that federal and state dollars are used to deliver cost-effective health care services to eligible Medicaid enrollees. An effective utilization management function is essential to ensure that:

- Federal and state funds spent on managed care are used appropriately.
- Members are provided health care services that are medically necessary, appropriate, and timely.
- Members and providers receive information in a timely manner and have an avenue to appeal MCO actions.

This report is the last in a series of reports on acute care utilization management in MCOs. It provides a summary and overview of utilization management information obtained from 19 MCOs by survey and during audits of 4 MCOs. The IG Audit Division recognizes that MCOs:

- Face challenges in providing an effective utilization management function that meets UMCC, UCMC, and TIC timeliness requirements for notification of prior authorization determinations.
- Encourage providers to submit electronic prior authorizations to increase the efficiency of the prior authorization process.
- Have different methods for implementing utilization management functions, which can lead to members not receiving equitable services between MCOs.
- Perform various analyses of utilization management data to assess the effectiveness and efficiency of their utilization management programs.
- Train, monitor, and evaluate utilization management personnel to ensure consistent, appropriate, and quality health care services are provided to members.

As a result of this series of audits, MCSD and the HHSC Office of Chief Counsel plan to discuss the prior authorization timeliness discrepancy with TDI, with the goal of establishing consistent timeliness requirements for notice of prior authorization determinations. Additionally, MCSD and the audited MCOs are taking corrective actions to address the findings identified in the audit reports.

The IG Audit Division thanks the management and staff of MCSD and the MCOs for their cooperation and assistance.

Appendix A: Objective, Scope, and Methodology

Scope

The scope of this summary of utilization management information includes (a) the first informational report in this series, which provided background, context, and a compilation of information provided by 19 Texas Medicaid and CHIP MCOs, and (b) the four MCO audits conducted by the IG Audit Division covering acute care utilization management in Texas Medicaid MCOs. This summary report covers the period from September 1, 2013, through August 31, 2015.

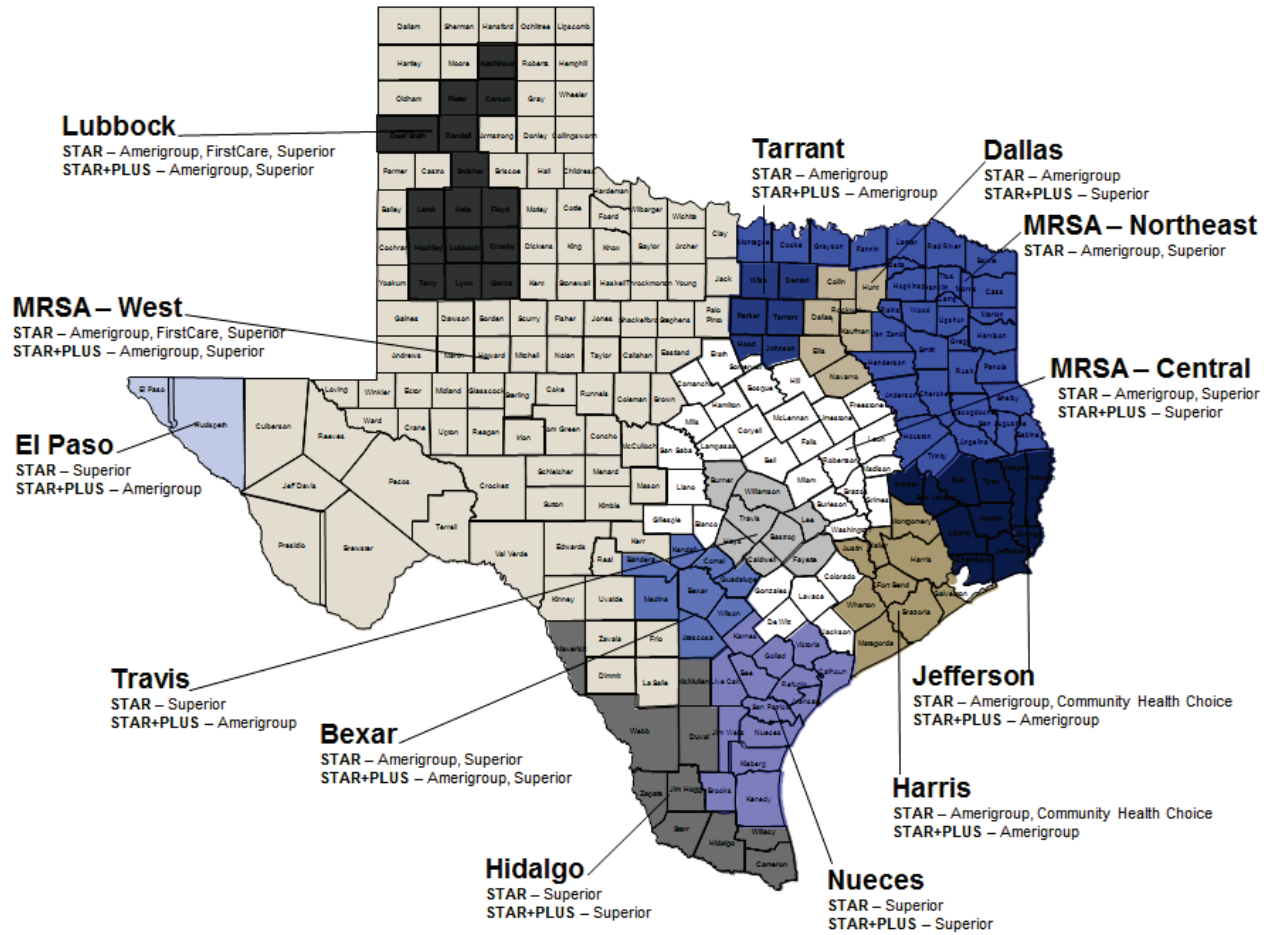
Methodology

The IG Audit Division collected and analyzed information for this summary report through observations, discussions, and interviews with responsible staff at MCSD and the MCOs, and through:

- Documentation received from the Request for Information and IG Audit Survey sent to 19 MCO health plans serving Medicaid and CHIP enrollees in Texas in January 2016.
- Four audits conducted on acute care utilization management in MCOs at Superior, Amerigroup, Community, and FirstCare.

The IG Audit Division conducted the series of audits discussed in this report in accordance with generally accepted government auditing standards (GAGAS) issued by the Comptroller General of the United States. The IG Audit Division did not produce this report in accordance with GAGAS. This report is not an audit report. This report consists of audited and non-audited information compiled by the IG Audit Division. Some of the information reported has not been validated, but in combination with audited information is sufficient to satisfy the purpose of this report.

Appendix B: Audited MCO Service Areas



Appendix C: Report Team and Distribution

Report Team

The IG staff members who contributed to this audit report include:

- Steve Sizemore, CIA, CISA, CGAP, Audit Director
- Marcus Garrett, CIA, CGAP, CRMA, Audit Manager
- Anton Dutchover, CPA, Audit Project Manager
- Melissa Towb, CPA, Senior Auditor
- Marcos Castro, Auditor
- Summer Grubb, Auditor
- Jennifer Carlisle, RN, Medical Auditor
- Tenecia Jackson, RN, Medical Auditor
- Lorraine Chavana, Quality Assurance Reviewer
- Mo Brantley, Senior Audit Operations Analyst

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- Tony Owens, Deputy Associate Commissioner, Health Plan Monitoring and Contract Services, Medicaid and CHIP Services Department
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- David D. Hall, Compliance Officer for Texas

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- Jay Hurt, President
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- Jenny Garza, Manager of Compliance

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- Ann Rote, President

Parkland Community Health Plan, Inc.

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- Brian Webber, Executive Director

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- Mark Sanders, President and Chief Executive Officer
- Cheryl Cizler, Vice President, Shared Services Compliance

Texas Children's Health Plan, Inc.

- Lou Fragoso, President

UnitedHealthcare Community Plan of Texas, L.L.C.

- Don Langer, President and Chief Executive Officer

Appendix D: IG Mission and Contact Information

The mission of the IG is to prevent, detect, and deter fraud, waste, and abuse through the audit, investigation, and inspection of federal and state taxpayer dollars used in the provision and delivery of health and human services in Texas. The senior leadership guiding the fulfillment of IG's mission and statutory responsibility includes:

- Sylvia Hernandez Kauffman, Principal Deputy Inspector General
- Christine Maldonado, Chief of Staff and Deputy IG for Operations
- Olga Rodriguez, Senior Advisor and Director of Policy and Publications
- Roland Luna, Deputy IG for Investigations
- David Griffith, Deputy IG for Audit
- Quinton Arnold, Deputy IG for Inspections
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- Judy Hoffman-Knobloch, Interim Deputy IG for Medical Services
- Anita D'Souza, Chief Counsel

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To Contact the Inspector General

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- Mail: Texas Health and Human Services Commission
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